Please complete this form and return to: bereavementsupport@shropshiremhs.com

Suicide Bereavement Service Professional Referral Form

Date

Referrer Details			
Referrer name		Contact number	
Relationship to client / name of organisation		Does the person know this referral is being made?	YES/NO

Client details							
Title		First name		Surname			
Known as				D.O.B			
Address							
Postcode				Contact number			
Email address				Best times to contact?			
How can we contact the person?							
Call	YES/NO	Text	YES/NO	Leave voicemail	YES/NO	Email	YES/NO
Emergency contact							
Name				Contact number			
Additional information							
Ethnicity							
Does the person have any communication needs?							
Hearing	YES/NO	Visual	YES/NO	Language	YES/NO	Other	YES/NO
Does the person have any physical access or health needs that we should be aware of?							
Please tell us about any support services the person is currently accessing				Friends & family	YES/NO	GP	YES/NO
Counselling	YES/NO	Mental health team	YES/NO	IAPT	YES/NO	Addiction services	YES/NO

About the person who has died			
Name		Relationship to the person	
Age		Date of their death	
Date of birth		Funeral date (if known)	

For internal office use only

Person taking referral:____ _____**Job title:**____ _____

Date & time of referral: _____

Additional Information/ Details Consider safeguarding, risk, other people who may be affected, immediate needs